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[60 FR 63178, Dec. 8, 1995, as amended at 70 FR 47490, Aug. 12, 2005]

Subpart C—Part B Carrier Payments for Physician Services to Beneficiaries in Providers

§415.100 Scope.

This subpart implements section 1887(a)(1)(A) of the Act by providing general conditions that must be met in order for services furnished by physicians to beneficiaries in providers to be paid for on the basis of the physician fee schedule under part 414 of this chapter. Section 415.102 sets forth the conditions for fee schedule payment for physician services to beneficiaries in providers. Section 415.105 sets forth general requirements for determining the amounts of payment for services that meet the conditions of this section. Sections 415.120 and 415.130 set forth additional conditions for payment for physician services in the specialties of radiology and pathology (laboratory services).

§415.102 Conditions for fee schedule payment for physician services to beneficiaries in providers.

(a) *General rule.* If the physician furnishes services to beneficiaries in providers, the carrier pays on a fee schedule basis provided the following requirements are met:

(1) The services are personally furnished for an individual beneficiary by a physician.

(2) The services contribute directly to the diagnosis or treatment of an individual beneficiary.

(3) The services ordinarily require performance by a physician.

(4) In the case of radiology or laboratory services, the additional requirements in §415.120 or §415.130, respectively, are met.

(b) *Exception.* If a physician furnishes services in a provider that do not meet the requirements in paragraph (a) of this section, but are related to beneficiary care furnished by the provider, the intermediary pays for those services, if otherwise covered. The intermediary follows the rules in §§415.55

and 415.60 for payment on the basis of reasonable cost or PPS, as appropriate.

(c) *Effect of billing charges for physician services to a provider.* (1) If a physician furnishes services that may be paid under the reasonable cost rules in §415.55 or §415.60, and paid by the intermediary, or would be paid under those rules except for the PPS rules in part 412 of this chapter, and under the payment rules for GME established by §§413.75 through 413.83 of this chapter, neither the provider nor the physician may seek payment from the carrier, beneficiary, or another insurer.

(2) If a physician furnishes services to an individual beneficiary that do not meet the applicable conditions in §§415.120 (concerning conditions for payment for radiology services) and 415.130 (concerning conditions for payment for physician pathology services), the carrier does not pay on a fee schedule basis.

(3) If the physician, the provider, or another entity bills the carrier or the beneficiary or another insurer for physician services furnished to the provider, as described in §415.55(a), CMS considers the provider to which the services are furnished to have violated its provider participation agreement, and may terminate that agreement. See part 489 of this chapter for rules governing provider agreements.

(d) *Effect of physician assumption of operating costs.* If a physician or other entity enters into an agreement (such as a lease or concession) with a provider, and the physician (or entity) assumes some or all of the operating costs of the provider department in which the physician furnishes physician services, the following rules apply:

(1) If the conditions set forth in paragraph (a) of this section are met, the carrier pays for the physician services under the physician fee schedule in part 414 of this chapter.

(2) To the extent the provider incurs a cost payable on a reasonable cost basis under part 413 of this chapter, the intermediary pays the provider on a reasonable cost basis for the costs associated with producing these services, including overhead, supplies, equipment costs, and services furnished by nonphysician personnel.

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(3) The physician (or other entity) is treated as being related to the provider within the meaning of § 413.17 of this chapter (concerning cost to related organizations).

(4) The physician (or other entity) must make its books and records available to the provider and the intermediary as necessary to verify the nature and extent of the costs of the services furnished by the physician (or other entity).

[60 FR 63178, Dec. 8, 1995, as amended at 70 FR 47490, Aug. 12, 2005]

§ 415.105 Amounts of payment for physician services to beneficiaries in providers.

(a) *General rule.* The carrier determines amounts of payment for physician services to beneficiaries in providers in accordance with the general rules governing the physician fee schedule payment in part 414 of this chapter, except as provided in paragraph (b) of this section.

(b) *Application in certain settings—(1) Teaching hospitals.* The carrier applies the rules in subpart D of this part (concerning physician services in teaching settings), in addition to those in this section, in determining whether fee schedule payment should be made for physician services to individual beneficiaries in a teaching hospital.

(2) *Hospital-based ESRD facilities.* The carrier applies §§ 414.310 through 414.314 of this chapter, which set forth determination of reasonable charges under the ESRD program, to determine the amount of payment for physician services furnished to individual beneficiaries in a hospital-based ESRD facility approved under part 405 subpart U.

§ 415.110 Conditions for payment: Medically directed anesthesia services.

(a) *General payment rule.* Medicare pays for the physician's medical direction of anesthesia services for one service or two through four concurrent anesthesia services furnished after December 31, 1998, only if each of the services meets the condition in § 415.102(a) and the following additional conditions:

(1) For each patient, the physician—

(i) Performs a pre-anesthetic examination and evaluation;

(ii) Prescribes the anesthesia plan;

(iii) Personally participates in the most demanding aspects of the anesthesia plan including, if applicable, induction and emergence;

(iv) Ensures that any procedures in the anesthesia plan that he or she does not perform are performed by a qualified individual as defined in operating instructions;

(v) Monitors the course of anesthesia administration at frequent intervals;

(vi) Remains physically present and available for immediate diagnosis and treatment of emergencies; and

(vii) Provides indicated post-anesthesia care.

(2) The physician directs no more than four anesthesia services concurrently and does not perform any other services while he or she is directing the single or concurrent services so that one or more of the conditions in paragraph (a)(1) of this section are not violated.

(3) If the physician personally performs the anesthesia service, the payment rules in § 414.46(c) of this chapter apply (Physician personally performs the anesthesia procedure).

(b) *Medical documentation.* The physician alone inclusively documents in the patient's medical record that the conditions set forth in paragraph (a)(1) of this section have been satisfied, specifically documenting that he or she performed the pre-anesthetic exam and evaluation, provided the indicated post-anesthesia care, and was present during the most demanding procedures, including induction and emergence where applicable.

[63 FR 58912, Nov. 2, 1998]

§ 415.120 Conditions for payment: Radiology services.

(a) *Services to beneficiaries.* The carrier pays for radiology services furnished by a physician to a beneficiary on a fee schedule basis only if the services meet the conditions for fee schedule payment in § 415.102(a) and are identifiable, direct, and discrete diagnostic or therapeutic services furnished to an individual beneficiary, such as interpretation of x-ray plates, angiograms, myelograms, pyelograms, or